CLAIMS ADJUDICATION REVIEW

State of Montana

December, 1980

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MONTANA
STATE CAPITOL • HELENA

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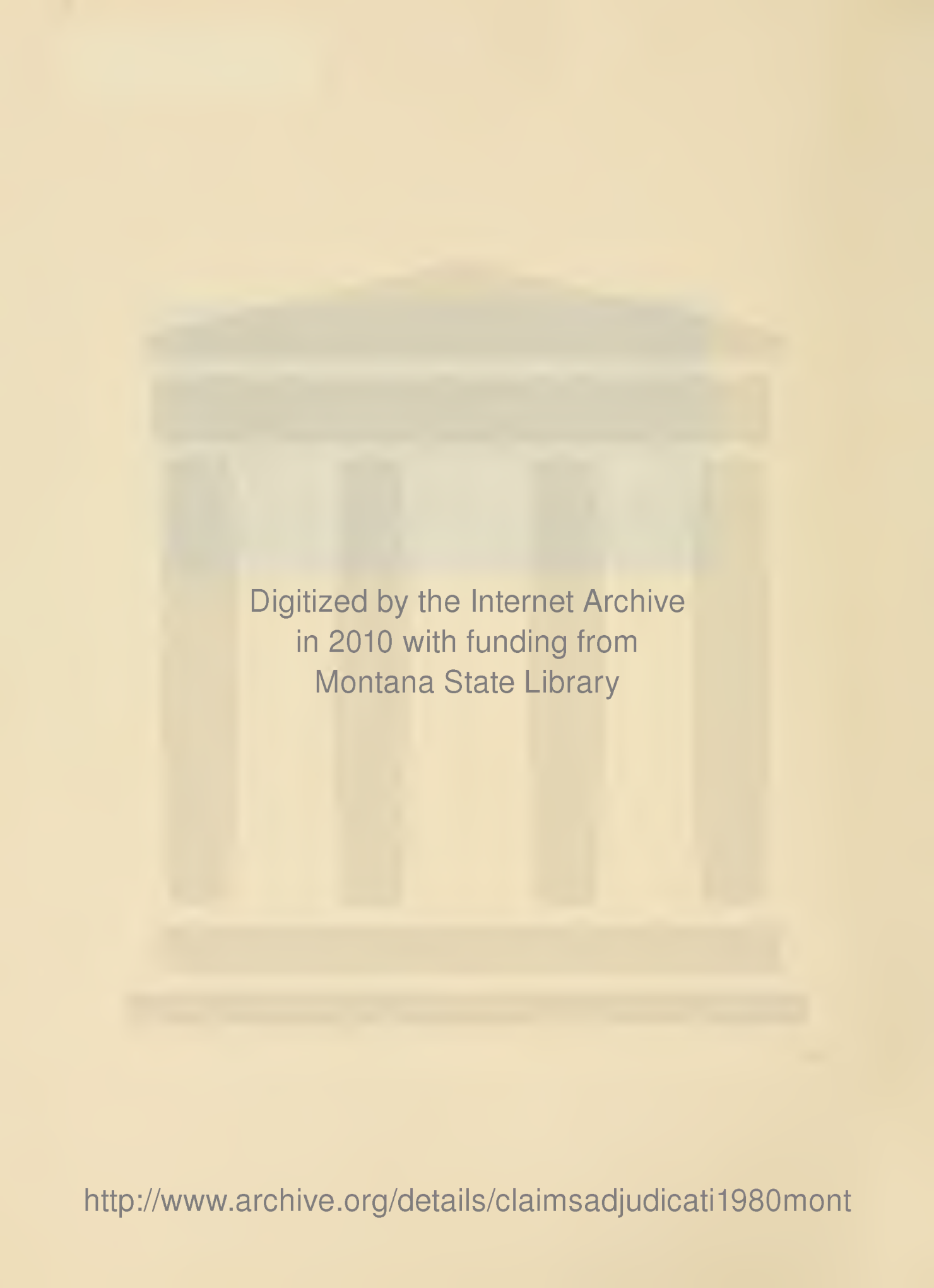

STATE OF MONTANA

Office of the Legislative Auditor

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December 1980

The Legislative Audit Committee
of the Montana State Legislature:

Transmitted herewith is the report on the review of the Blue Cross of Montana health care and Aetna dental care portions of the State Employee Health Benefits Plan for the periods September 1, 1979 to July 31, 1980 and September 1, 1979 to August 31, 1980, respectively.

The review was conducted by Peat, Marwick, Mitchell & Co., CPA's, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

Written responses to the report are included in the back of the report.

Respectfully submitted,

Morris L. Brusett

Morris L. Brusett, CPA
Legislative Auditor

Peat, Marwick, Mitchell & Co.

Certified Public Accountants

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Kansas City, Missouri 64199

December 12, 1980

PRIVATE

Mr. Morris L. Brusett, C.P.A.
Legislative Auditor
State of Montana
State Capitol
Helena, Montana 59601

Dear Mr. Brusett:

We have completed our review services for the State of Montana's insurance benefit plans and are pleased to present the draft of our report.

Our report is presented under the following headings:

- Introduction
- Results of Review and Audit
- Claim Comparison
- Conclusions and Recommendations

The results of the review services provided by the Montana Foundation For Medical Care (Foundation) are not included in this report. The Foundation's report will be presented separately.

MAJOR CONCLUSIONS

The major conclusions contained in our report include:

- Eligibility of claimants and validty of claims.
  - Aetna and Blue Cross of Montana (BC) have effective methods of verifying claimant eligibility.
  - Most claims are reviewed appropriately by both Aetna and BC.
  - Aetna and BC both approve claims for payment without appropriate review of coordination of benefits.
  - Aetna and BC approve claims for payment without appropriate review of duplicate payments.

. Propriety of amounts paid on claims submitted.

- Both Aetna and BC identify and pay appropriate amounts on most claims.

- BC does not review appropriateness of treatment plan.

- Aetna processes claims without appropriate review of total charges.

. Plan operation in accordance with master contract.

- BC contract agrees with State's copy of master contract. Claims administration varies from master contract in the areas of obesity and LPN charges.

- Aetna contract and claims administration vary in the areas of dependent eligiblity; certain oral exams; customary charge limits; and payment for crowns, anesthesia and fluoride.

BLUE CROSS OF
MONTANA RESPONSE

BC responded in writing to our report. A copy of the written response is presented as Exhibit D. Our comments regarding BC's letter are presented below.

Claims Verification. BC states that our comments regarding claim processing for subscribers may lead a reader to conclude that all submitted claims for treatment following termination of coverage will be paid. The BC plan provides certain coverage for subscribers who are disabled on the date their coverage is terminated, as described in the extention of benefits paragraph of Article VI of the Master Contract. These and only these charges are payable under the Plan following termination of coverage. Our comments here are intended to amplify our report comments.

Claims Calculation,
Customary Charges. BC states that the primary source of customary charge data is the BC Survey. The Montana Workers' Compensation factors are used only as a secondary source of data. Our report does not describe a primary or secondary source for this data. The recommendations in our report are not affected by this clarification.

Master Contract Review.
Conclusions,
Recommendations. BC's letter states that the inclusion of obesity charges was at the direction of the Montana Insurance Commissioner. BC's letter also states that the liberalization on nurses services involves only one LPN who is named by BC.

We agree that BC has an obligation to conform with the Commissioner's directions. We also wish to note that the use of the LPN in this one situation has the effect of reducing the cost of care for

an individual by eliminating the need for frequent hospitalization. The purpose of our recommendation is to protect all parties by having the State and BC agree to these two plan modifications.

Coordination of Benefits. BC stated their position and attitude regarding COB claims administration in the letter. Based upon our experience with other health care plans; the strict administration of aggressive COB procedures, especially during periods of economic recession, will produce positive financial results. Our recommendations remain unchanged.

AETNA RESPONSE

Aetna responded in writing to our report. A copy of the written response is presented as Exhibit E. Our comments regarding Aetna's letter are presented below.

Eligibility Verification. Aetna is correct. The notes of our interview with Elaine Youngkrantz indicate that cards are mailed to Hartford. The State's Administration Manual confirms that no cards are mailed to Hartford. This has no effect on our report.

Customary Charges. The notes of our interview with Elaine Youngkrantz indicate the use of outside statistical data for prevailing fees. The Aetna data base and method appear to be appropriate and this correction has no effect on our report.

Aetna's comments on cost control here are correct and support our statement of fact in the report.

Claim Turnaround Time. Our work papers and notes of our exit meeting with Aetna personnel support the data presented in our report.

Results of Claim Audit. Our work papers do not support Aetna's statement regarding correction of errors prior to our audit. Aetna states that PMM&Co. identified four errors in Exhibit B. Our work papers and report show eight errors identified by PMM&Co. One claim error appearing in Exhibit B was identified by the dentist (Number 3), one was a procedure error and may not have resulted in an over payment (Number 5), the other two had a total net underpayment of $1.50 (Numbers 1 and 2). None of these four claim errors were described as being identified by PMM&Co.

Master Contract. We believe items 2, 4 and 6 in Aetna's letter are subjects requiring agreement between Aetna and the State. Items 1 and 3 are statements of fact and may need no further discussion. Item 5 has been corrected. The State did not include the renewal date amendment with the master contract provided to us.

Recommendations. These items are commented on below using Aetna's numbering system.

1. The information is available to the State. Our recommendation is that the State use it to audit eligibility.

2. Aetna's procedure is to require C.O.B. information. Our recommendation is that this procedure be followed by Aetna claim processors.

3. A review of all overrides may have an adverse effect on turnaround time. However, failure to review overrides may have an adverse effect on claim accuracy. Our recommendation for review of overrides should not affect turnaround time if the review is done subsequent to the processors activity. Errors could be corrected prior to mailing of benefit payments.

4. Again, our recommendation is that processors follow procedures.

6. (Apparently 5 was omitted) The availability of information regarding other dental plans will aid the claims processor if the employee states that the spouse is working but has no other dental coverage. This would permit the processor to request additional data if C.O.B is suspected.

IDENTIFIED NET OVERPAYMENTS

During our review, we identified approximately $10,100 in overpayments and improper charges to the State's contracts.

* * * * *

We appreciate the opportunity to be of service to the State of Montana in this most important program.

Yours truly,

Peat, Marwick, Mitchell & Co.

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EXHIBITS

I - INTRODUCTION

The State of Montana (State) provides health care and dental care insurance as part of an overall employee benefit program for State employees including elected officials, certain retired employees and their dependents. The State pays the premium for active employees and employees pay the premium for dependent coverage. The State does not contribute toward the premium for employees on leave of absence.

Approximately 10,400 employees are participating in the insurance programs. About 50 percent of the employees have elected to insure their dependents.

Blue Cross of Montana (BC) was selected to provide the health care insurance for all employees and dependents effective September 1, 1979. As of that date, Aetna Life and Casualty (Aetna) was selected to provide the dental care insurance along with life and accidental death and dismemberment insurance.

Both BC and Aetna initially issued their master contracts with renewal dates of September 1, 1980. By mutual agreement with the State, these master contracts were renewed as of August 1, 1980.

PURPOSE OF SERVICE

Section 2-18-816, MCA (Montana State Law) requires the State Legislative Auditor or an independent certified public accountant to perform an annual audit of the State employee group benefit plans. Peat, Marwick, Mitchell & Co. (PMM&Co.) was selected to perform audit and review services for the BC plan and Aetna dental plan pursuant to an Audit Contract dated October 9, 1980. The purpose of the services was to comply with Section 2-18-816, MCA.

OBJECTIVES OF SERVICE

The objectives of our audit and review service, were stated in the original request for proposal dated September 5, 1980 from Mr. Morris L. Brusett, C.P.A., Legislative Auditor. These objectives are:

- Determine the eligibility of persons submitting claims and the validity of the claims based upon supporting documentation,
- Determine the propriety of amounts paid on claims submitted, and
- Determine if the plan is operating in accordance with contract provisions.

By mutual agreement, PMM&Co. and the State agreed that Montana Foundation for Medical Care (Foundation) would provide the following services:

- Review appropriateness and necessity of medical services,
- Review the quality of medical care provided, and
- Review the level of medical care provided.

The Foundation's services represent an increase in the objectives to include a determination of the appropriateness, necessity, quality and level of medical care provided to State employees and their dependents.

Also it was agreed that PMM&Co. would compare the State's claims experience to similar data available on a regional and national basis.

SCOPE OF SERVICES

The scope of our services was defined to include the BC plan and the dental care plan insured by Aetna. Our services did not extend to other employee benefit plans for State employees.

Number of Claims Reviewed

Our audit of specific claims included 200 claims processed by BC during the period September 1, 1979 to July 31, 1980 and 200 claims processed by Aetna during the period September 1, 1979 to August 31, 1980. Aetna claims for August, 1980 were included in our audit because the Aetna master contract did not reflect the change in renewal date to August 1, 1980.

Method of Selecting Claims

We used a judgmental selection technique to select paid claims for our review. The technique is designed to concentrate our audit activity on those claims that tend to have a higher frequency of error. These claims include:

- Large claims - claims involving over $10,000 in medical expenses and claims involving over $300 in dental expenses,
- Dependent claims - claims involving a possible coordination of benefits with other insurance coverage,
- Surgical claims - claims involving large professional service charges subject to reasonable and customary limitations of the master contract,
- High Frequency claims - claims involving several treatments over a period of time,
- Duplicate Charges - claims involving identical charges for services on the same date, and
- Claims incurred soon after coverage becomes effective - claims involving possible pre-existing conditions.

We also selected claims without regard to the above criteria to evaluate the two claims systems' effectiveness in processing routine claims.

Areas of Review and Audit

Our work plan involved test work and/or interview procedures in the following areas:

- Eligibility Verification,
- Claim Verification,
- Claim Processing Method,
- Internal Control,
- Claim Calculation,
- Claim Turnaround Time, and
- Contract Provisions.

Each of these areas will be discussed in the RESULTS OF REVIEW AND AUDIT and CONCLUSIONS AND RECOMMENDATIONS sections of this report.

II - RESULTS OF REVIEW AND AUDIT

The results of our review and audit are separately presented for the BC and Aetna plans. Each of the areas reviewed and/or audited are discussed herein.

BLUE CROSS OF MONTANA

The results of our review and audit services regarding the BC plan are presented below.

Eligibility Verification

All enrollment activity begins at the State Agency or department level. New employees are given enrollment materials to be completed. The completed materials are then forwarded to the State Personnel Division. After processing by the State, the enrollment card is sent to BC in Great Falls.

BC reviews the enrollment card to be sure it is completed and that the effective date of coverage is appropriate based on the date of employment and plan provisions.

If an individual or family applies for insurance more than 30 days after the date such person was otherwise eligible, evidence of insurability is required in addition to the normal enrollment forms.

Once the effective date of coverage has been verified (and insurability is determined, if required) the employee's Social Security number is entered into the membership records to record his participation in the plan along with information regarding dependents to be covered, if any.

Changes in coverage, such as adding dependent coverage, and terminations of coverage are processed in much the same manner.

These activities are performed by BC underwriting and membership records people and are not performed by BC claim adjudicators responsible for processing State employee claims.

Claim Verification

All claims received by BC are date stamped the day they are received. All plan participant records are maintained on the BC computer. The first step in verifying the claim is to review the material submitted. This usually includes a hospital or doctor's statement showing:

- Patient's name,
- Relationship of the patient to the State employee,
- Employee's Social Security Number,
- Statement that he is employed by the State,

. Itemized listing of services performed and the dates of service,

. Diagnosis, and

. Information regarding other insurance coverage.

To eliminate the possibility of duplicate payments, original statements are required and "Balance Forward" items are not accepted.

The date on the submitted claim is compared to membership information contained in the computerized records. If the Social Security Number and name agree and if the patient is covered as of the treatment date, the claim is verified and the adjudication process can continue.

The BC doctor's claim form requests information regarding the date symptoms first occurred. This date is checked by the adjudicator to determine if the claim is for a pre-existing condition.

If a check of the membership records shows the employee or dependent is not covered, BC requests coverage information from the State's Employee Benefits Section, Department of Administration. If coverage has terminated, the claim may then be processed under the extended benefits provision of the master contract.

Claim Processing Method

BC uses a manual claims processing method supported by computerized membership and claim history files.

After the claim has been verified, an adjudicator reviews the claim to make sure that all pertinent information has been provided. Any missing information is requested from the doctor, hospital or patient.

The claim is then processed for payment using BC procedures regarding specific types of claims. The plan of benefits is relatively simple. Eligible charges are payable at 90 percent or 100 percent depending on the type of claim and amount of expenses during the year. Comments regarding coordination of benefits (COB) and reasonable and customary review are presented below.

Internal Control

As stated above, underwriting and membership records personnel enter all information regarding employee eligibility. Claims department personnel process the claims and authorize payment.

Checks are computer printed. Office Services Department personnel sign the claim checks using a signature plate maintained in a safe in the Accounting Department. Personnel who operate the check signing equipment do not have access to the safe.

Voided checks are rare. If a check is voided for any reason, it is sent to the Accounting Department for proper adjustment to daily check totals and the check is marked "Void."

Claim Calculation

All claims are reviewed to determine:

- Nature of claim,
- Customary charges, and
- Coordination of Benefits.

The major steps in this process include:

- Nature of Claim. The claim forms or statements will indicate whether or not the claim resulted from an accident (including work related accidents), a diagnosis, and a description of how the accident occurred or date the illness began. If this data is not provided in the doctor's claim form or statement, the missing information is requested.

- Customary Charges. Hospital charges are not reviewed by BC to determine if charges are of a customary level. Most BC member hospitals participate annually in a BC rate review to establish acceptable charges.

  Professional fees are reviewed for customary charges by referring to several published tables of relative values for specific procedures. Each procedure has been assigned a unit value by the organizations publishing the tables. The primary tables are:

  - Montana Relative Value (MRV) Table,
  - California Relative Value (CRV) Table, and
  - Current Physician's Terminology (containing descriptions of procedures).

  The unit values for the MRV table are developed from a survey conducted by BC. The unit values for the CRV table are taken from published values used by the Montana Workers' Compensation Division. If a procedure is not listed in the tables, the Medical Director will establish a reimbursement amount.

- Coordination of Benefits (COB). If the claim forms or statements indicate evidence of other insurance, the claim is routed to a COB specialist. She will then decide to pay the claim or hold the claim and request further data.

  If the State's plan is primary, the claim is paid in full.

  If BC has not determined who is primary, the claim is paid if it is under $500 and a letter is sent to the patient requesting a return of any amounts received from other insurance.

  If the claim is over $500 or if the State's plan is secondary, no payment is made until information on other insurance is obtained.

COB data is requested annually from all BC participants. Information regarding other insurance is coded and entered into the computer membership record files to assist in identifying COB. Many participants elect not to respond to this request and as a result the data is incomplete.

- Reasonableness of Service. Reasonableness of service is only reviewed on an indirect basis. Certain claims (based upon procedure, amount of charge, length of stay in the hospital and other factors) are reviewed to determine that the amount of payment is in compliance with the terms of the master contract and to establish the amount of payment.

- Accuracy of Calculations. The claims adjudicator re-adds each statement to verify that the total charges have been added correctly by the hospital and/or the doctor. Noncovered items are subtracted from the statement and the claim is paid at 90 percent or 100 percent based upon the master contract provisions.

- Cost Containment Activity. The major cost containment effort by BC is the review of claims for COB recovery and Third Party Liability. The master contract contains a subrogation provision allowing BC to recover if a third party is liable for losses sustained. BC legal advisors are used in subrogation. To our knowledge BC has not accelerated its COB activities, developed incentives to reduce cost through contract modifications and education programs, encouraged the use of second opinions for surgical procedures or encouraged the use of alternate treatment programs.

Claim Turnaround Time

Claim turnaround time is measured from the date a claim, including all proper documentation, is received by the claim processing organization (BC) to the time the benefit check is mailed.

The medical claims reviewed for turnaround time were claims involving large payments, long hospital confinements, COB claims and other claims involving more adjudication time than average BC claims. Forty percent of these claims were paid within 14 days. Twenty-five percent were paid in over 14 days, however, PMM&Co. believes the delay was reasonable due to the investigation required. Twenty percent were paid in over 14 days, but no reason for the delay was found. Fifteen percent of the claims reviewed for turnaround time did not show a received date or the date was illegible.

Results of Claim Audit

The results of our audit work on the 200 claims indicated that BC is processing most claims with a high degree of accuracy. We did identify several claims that indicate a need for improved processing techniques and more controlled payment policies.

The items presented in Exhibit A represent claims we audited that contain errors of significant size or claims that demonstrate a need for changes in the processing system.

Other frequently noted items included:

- High frequency of claims where claim adjuster did not document the calculation of the excluded charges or amount to be paid. (17 claims so noted)

- Frequent claims processed where customary charge allowance was not documented. (6 claims so noted)

Master Contract Review

The master contract provided to us by the State agrees with the master contract used by BC for claims purposes. The following items were noted during the master contract review:

- Page 5, item 15 excludes treatment for obesity. A pencil entry on the master contract in the claims department states that certain obesity treatment will be eligible for benefits under the plan. BC indicated this provision was modified to provide limited coverage for obesity as requested by the Montana Insurance Commissioner.

- Page 12, item 1 provides coverage for Registered Nursing services. A pencil entry on the master contract in the claims department states that the Services of a Licensed Practical Nurse are now being paid.

No other discrepancies were noted during our review of the master contract.

Premium Rates

The BC rate charged for employee coverage is in excess of the rate needed to support employee claims. The BC dependent rate is below the level required to support dependent claims. This results in an imbalance of cost to the State for employee health care cost.

AETNA LIFE
AND CASUALTY

The results of our review and audit services regarding the Aetna dental plan are presented below.

Eligibility Verification

The initial process of enrolling employees and dependents is identical to the procedure for BC.

Once completed, enrollment forms are sent to Aetna's Home Office in Hartford. The forms are reviewed in Hartford and the enrollment data is entered into the computer participant information system. The Seattle claims office may access this data with CRT's used to process claims.

All changes affecting coverage and data regarding insurability of people requesting coverage after their eligibility date are forwarded to Hartford, reviewed and entered into the computer system.

Aetna is also using Social Security numbers as certificate numbers for identification purposes.

Entry of participant eligibility data into the claims system is performed by Aetna employees in Hartford and not by claims personnel in Seattle.

Claim Verification

All claims received by Aetna are date stamped the day they are received. All plan participant records are maintained on the Aetna computer. The first step in verifying the claim is to review the material submitted. The claim is usually submitted on an Aetna dental claim form. The review includes checking that all required information is submitted and that the form is signed by the dentist and the employee. A visual check is also made to determine that the dentist has completed his section of the form rather than the employee.

The participant data on the claim form is then entered into the CRT to verify that the employee is insured as of the treatment date.

If Aetna can not verify that the employer or dependent is insured, a coverage verification request is sent to the State's Employee Benefits Section, Department of Administration. If coverage has terminated, the claim may then be processed for any services provided prior to termination and/or services covered under the extended benefits provision.

Claim Processing Method

Aetna uses a computerized, fileless claim processing system for processing dental claims.

After the claim has been verified, the processor enters all pertinent claim data into the computer, using the CRT. This information includes:

- Dentist's number,
- Date of service,
- Procedure code for each service performed, and
- Charge for each service.

The computer then checks the history file as a check against duplicate charges and repeat routine services performed within six months of a previous routine service.

The computer also contains information regarding:

- Customary charge limits,
- Plan benefit formula, and
- Previous claims filed involving COB.

The computer evaluates the data entered by the processor and determines the payment to be made. Comments regarding COB and customary charges are presented below.

Internal Control

As stated above, Aetna employees in Hartford enter all participant data into the computer system. Claims department processors in Seattle enter claim data into the computer system. Once a claim has been processed, the computer in Hartford prints and signs the benefit checks.

Claim Calculation

The majority of the claim calculation process is performed by the computer. The computer is programed with benefit limits, excluded services, customary charge data and information regarding COB from previous claims. The major steps in the claim calculation process are:

- Nature of Claim. The claim form contains questions designed to identify claims involving:

  - Accident related claims including occupational and auto accidents,

  - Orthodontics,

  - Initial placement or replacement of prosthetic devices.

  In addition, the date of service must be shown to aid the processor in evaluating treatment prior to the effective date of insurance or following termination of insurance.

If this data is not provided, and if there is reason to need any missing data, it is requested from the dentist or patient.

- Customary Charges. Aetna gathers customary charge information from their own claim statistics plus statistics published by the Health Insurance Association of America. This information is updated every 6 months and contains historical charge data by procedure. This information is available on a zip code basis. Aetna defines the customary charge limit for the plan to be the 85th percentile by zip code for each procedure. This upward limit is modified by a $5.00 per procedure variance. If a charge exceeds this limit, less than the total charge will be recognized for payment. The computer alerts the processor and approves the lower payment.

- Coordination of Benefits. The claim form requests information regarding other dental insurance. This information together with the computer history regarding previous claims filed with COB information allows the processor to determine whether further COB data is needed or if the claim can be processed.

Aetna's procedure is to request COB data if the patient fails to answer the claim form questions regarding other dental insurance. If the patient states that he has no other dental insurance or if the State's plan is primary, the claim is processed.

If the State's plan is secondary or if further data is needed, the data is requested and the claim is held pending further data.

. Reasonableness of Service. All claims involving

- charges in excess of 150 percent of the allowable charge limit,

- bridge work,

- procedures without a procedure code, and

- procedures without an established range of fees

are reviewed by Aetna's claims analysis technician. If she feels unqualified to make a determination, the claim is referred to Aetna's dental consultant for a final determination regarding reasonableness and/or acceptable fee.

. Crowns. The dental plan pays 50 percent of the actual charge for silver, silicate, plastic and amalgam restoration. The contract specifies that for other types of fillings, crowns, inlays and onlays, the allowable charge is limited to what would have been allowed for amalgam restoration.

Initially crowns were paid at the rate for a 3 surface amalgam filling. After discussion with the State, Aetna raised the allowance to the rate for a 4 surface amalgam filling.

. Cost Containment Activity. The two major cost containment activities employed by Aetna are:

- Administration of COB provision and

- Administration of customary charge limitations.

To our knowledge no effort is made to encourage use of routine oral examinations, cleaning or the application of fluoride as a method of reducing the need for restorative procedures. Apparently no effort is made to encourage performance of restorative procedures soon after the need is diagnosed.

Claim Turnaround Time

The turnaround time for Aetna was measured from date received to date processing was completed. Aetna's payment procedure is to make bulk payments to dentists twice each month. If payment is to be made to the participant, thepayment is made the day following the completion of processing.

Seventy-five percent of the claims we analyzed were processed in 10 or fewer calendar days. Ten percent of the claims were paid in over 10 days, however, appropriate reasons for the delays were documented. Fifteen percent of the claims were processed in over 10 days, but no reason for the delay was indicated.

Results of Claim Audit

The results of our audit work on the 200 claims indicated that Aetna did not process claims during the first plan year with a high degree of accuracy on nonroutine claims. We identified several claims that indicate a need for additional processor training and closer supervision of processor authority.

The items presented in Exhibit B represent claims we audited that contain errors of significant size or claims that demonstrate a need for improved processor training or supervision.

The total net overpayments identified during our audit of 200 claims was $1,029.50. This represents a $5.00 average overpayment per claim audited. While it is inappropriate to conclude that the results are indicative of the payment acuracy of all claims processed, the results do indicate a need to improve the payment accuracy of processors assigned to the State's plan.

The major areas of deficiency are:

- Failure to identify or investigate COB,
- Failure to identify ineligible charges,
- Failure to identify ineligible dependents, and
- Failure to identify duplicate charges and Pre-Dent items.

Master Contract Review

The master contract provided to us differs in the following areas from the contractual outline and administrative procedures in the claims department:

- Claim department information regarding eligibility does not include information regarding retired employees under age 65.
- Oral examinations by specialists prior to treatment are paid at 50 percent of charge. The master contract does not reflect this.
- Crowns initially were paid at the rate for a 3 surface amalgam filling. Later this was increased to the rate for a 4 surface filling. The master contract does not reflect this.
- Customary charge limit, including the $5.00 variance is not defined in the master contract.
- Master contract renewal date has not been amended to August 1, 1980.

. Aetna plan does not cover charges that are not necessary. Aetna defines anesthesia for simple restoration as unnecessary. Aetna plan also excludes fluoride for adults. Aetna, however, pays for such anesthesia and fluoride if the charge is combined with covered charges and the combined charge does not exceed the allowable limit for the covered charges.

III - CLAIM COMPARISON

The claim data available from BC has been compared to available data on a statewide and on a national basis. This information is presented as Exhibit C.

This information has previously been presented to the State. No additional claim data for the State's BC plan has been made available to us. Published data for the first nine months of 1980 is not yet available.

The State may wish to request appropriate claim data from BC on a quarterly basis including specific claim data on a diagnosis basis and analysis of COB savings.

IV - CONCLUSIONS AND RECOMMENDATIONS

Our conclusions and recommendatins are presented separately for BC and Aetna.

CONCLUSIONS REGARDING BC

Our conclusions regarding BC are presented below for each of the objectives of our service.

- Determine the eligibility of persons submitting claims and the validity of claims based upon supporting documentation.
  - BC system appears to be effective in determining eligibility of persons submitting claims.
  - BC system for verifying validity of claims appears to be effective except for COB procedures which tend to permit claims to be paid without sufficient verification of other medical insurance.
  - BC system does not appear to be completely effective on duplicate payments, but errors appear to be retroactively corrected.
- Determine the propriety of amounts paid on claims submitted.
  - BC system does appear to identify and pay appropriate amounts on claims that do not involve COB or duplicate payments.
  - BC system tends to rely on provider and participant to identify propriety of claim involving COB.
  - BC system does not evaluate appropriateness of treatment plan.
- Determine if the plan is operating in accordance with contract provisions.
  - BC appears to be paying claims in accordance with plan provisions except as noted in the next two items.
  - Administrative procedures would permit payment of certain obesity expenses which are excluded in the contract.
  - Administrative procedures would permit payment of LPN expenses under certain circumstances which are excluded in the contract.
- Other conclusion areas include:
  - Documentation of payment amounts tends to be omitted.
  - Claim turnaround time delays tend not to be documented.
  - Internal Control appears to be appropriate.

- Cost containment opportunities do not appear to have been discussed with the State.

- Premium allocation between employees and dependents is not supported by claim history. Employee rates appear to be higher than historical claims could support and dependent rates appear to be substantially below historical claim levels.

RECOMMENDATIONS REGARDING BC

PMM&Co. makes the following recommendations regarding the BC plan:

. Social Security numbers and admission dates should be provided to the State on a monthly basis for eligibility verification audit by the State.

. BC should revise COB procedures to investigate possible duplicate insurance prior to paying claims between $100 and $500. BC should inform providers and patients of the need for this information and secure the cooperation of the State, doctors and hospitals in obtaining this information.

. BC should instruct adjudicators to be more careful in their review of claims for possible duplicate payments. BC should also request that providers not submit statements for services more than once unless requested by BC.

. BC and State should agree to engage the Foundation or a similar organization to conduct concurrent review of medical necessity and reasonableness of treatment plan.

. Present administrative variances in contract provisions should be agreed to or rejected by the State.

. BC should increase the documentation of action taken regarding claim processing in areas of allowable charges and delays in turnaround time.

. BC and State should discuss the use of cost containment features to reduce the cost of health care.

. State should determine if premium allocation imbalance is in agreement with State law.

CONCLUSIONS REGARDING AETNA

Our conclusions regarding Aetna are presented below for each of the objectives of our service.

. Determine the eligibility of persons submitting claims and the validity of claims based upon supporting documentation.

- Aetna system appears to be effective in these areas except for the following four items.

- Aetna processors appear to have overridden the system edits for dependent eligibility and eligible services.

- Aetna processors appear to have failed to identify COB claims even when such information is present on claim forms.

- Aetna processors appear to have processed claims without balancing to the sum of the charges. This has resulted in under payments and payments for services not performed.

- Aetna processors appear to have overridden edits for previous payments resulting in duplicate payments.

. Determine the propriety of amounts paid on claims submitted.

- Aetna processors appear to be paying appropriate benefits except in the areas described above.

- Aetna appears to be evaluating reasonableness of treatment and customary levels of charges appropriately.

. Determine if the plan is operating in accordance with contract provisions.

- The master contract appears to differ from claim department instructions in the areas of dependent eligibility, oral exams by specialists and renewal date.

- The master contract does not define customary charges to include the $5.00 variance.

- The master contract is not specific regarding payment for crowns, anesthesia and fluoride treatment for adults.

. Other conclusion - Claim turnaround time appears to be reasonable. Improvement could be made in documentation of reasons for delay.

RECOMMENDATIONS
REGARDING AETNA

PMM&Co. makes the following recommendations regarding the Aetna dental plan:

. Social Security numbers and treatment dates should be provided to the State on a monthly basis for eligibility verification audit by the State.

. Aetna should instruct processors to require COB data on all claims prior to processing and to process claims only after a complete review of COB information.

. Aetna claim supervisor should review all processor overrides of system edits.

- Aetna should instruct processors to balance charges on the claim form with data entered into the system.

- Aetna and State should agree on contract variances between master contract and claim department administrative procedures.

- Aetna should obtain data regarding dental plans provided by major employers in Montana as an aid in processing COB claims.

GENERAL COMMENTS AND RECOMMENDATIONS

This section of the report has been critical in nature. The results of our service tend to indicate that both BC and Aetna are processing the majority of claims on a timely and accurate basis.

The recommendations in this report should be communicated to both BC and Aetna. PMM&Co. recommends these specific areas be reviewed again three to six months following the communication of these recommendations.

PMM&Co. further recommends that COB activity be intensified and that this activity be coordinated among BC, Aetna and the State to insure that appropriate information is obtained.

Exhibit A

STATE OF MONTANA

Blue Cross of Montana
Claims Adjudication Errors

Description	Comment
$463 claim on dependent. COB not checked by claims adjudicator. Check returned by patient.	Claims under $500 involving COB are paid without reviewing further. BC relies on the patient to check COB after the claims is paid.
$300 claim on son of female employee. Doctor did not answer COB questions on claim form.	Possible COB recovery was never checked by BC. This could have produced plan savings of $270.
$2,376 claim paid. Item was reversed 60 days later because COB was discovered.	Return of check by hospital. Error could have resulted in large over payment.
$300 error on hospital statement. Claim adjudicator did not discover error.	Hospital notified BC of error. Error could have resulted in $300 overpayment.
Patient stated that claim was work related. BC did not investigate. $5,100 claim.	Possible $5,100 overcharge if the claim was work related. Claim was for a heart attack. Workers' compensation liability may not exist, but the item was missed by the adjudicator.
$8,706 claim paid on wife of employee. Wife works for company with BC coverage. Claim charged to State plan in error. PMM&Co. identified the error.	Error caused by failure to check COB properly. Overpayment of $8,706.
$5,744 claim. Possible self-inflicted, accident, subrogation. Accident report completed by spouse and stated no accident.	Claim paid at 100 percent rather than 90 percent. Probable over payment of $250. Claim adjudicator failed to request history and profile prior to paying claim.
$12 claim. Improper documentation of reason for treatment. Doctor returned payment.	Claim had been paid by Workers' Compensation. Claim adjudicator failed to identify reason for treatment.
$350 duplicate claim. Claims adjudicator paid same claim twice. Amount returned by doctor.	Claims adjudicator did not check claim history. Possible $350 overpayment avoided by return.

STATE OF MONTANA

Blue Cross of Montana
Claims Adjudication Errors, Continued

Description	Comment
$1,352 claim paid. COB discovered after payment was made. Payment was returned.	Incomplete COB review could have produced large overpayment.
$1,368 claim paid. No evidence of COB check. No claim form in BC records.	Improper documentation. Possible COB.
Claim over $10,000. Paid full cost of private room. PMM&Co. identified the error.	$320 overpayment. Claims adjudicator did not reduce for private room.
$45 claim. State's employee received check and returned it. He states he did not receive the treatment.	Possible hospital error.
$353 claim paid. Patient reported COB and returned the payment.	$353 overpayment avoided by honesty of patient.

Exhibit B

STATE OF MONTANA

Aetna Dental Plan
Claims Adjudication Errors

Description	Comment
X-rays not paid with other procedures processed for payment.	Processor failed to enter the service and fee data for the x-rays. The result was a $13.50 under payment.
Claim form described other dental insurance. Processor paid the claim without regard to this information.	Overpayment of $12.00.
COB not checked by Aetna. Dentist returned the payment.	After proper corrective entry, overpayment was avoided.
Claims paid twice. Dentist sent duplicate billing. PMM&Co. identified the overpayment.	Processor appears to have overridden a computer edit. Aetna called the dentist. He will return $85.00 overpayment.
Claim processed without data regarding employment of spouse or other dental insurance.	Processor failed to request such data prior to paying claim.
Claim form showed other dental insurance information. Claim was for dependent child of female employee. PMM&Co. identified the error.	Failure to process claim with provided data. Probable overpayment of $61.00.
Dependent husband over age 65 claim for ineligible services. PMM&Co. identified the error.	Processor did not check patient's age. Claim was paid. $542 overpayment.
Claim for root canal paid twice. PMM&Co. identified the error.	Processor error. Overpayment of $33.
Dentist submitted treatment plan (Pre-Dent) prior to performing services. Treatment plan was for ineligible service. PMM&Co. identified the error.	Processor paid for services not performed and ineligible. Overpayment was $102.
Claim paid twice for crowns. PMM&Co. identified the error.	Overpayment of $90.
Claim filed for services performed on spouse. Employee is insured for employee coverage only. PMM&Co. identified the error.	Processor paid claim for uninsured dependent. Overpayment of $138.
Claim for x-ray and oral exam paid at 50 percent rather than 100 percent. PMM&Co. identified the error.	Aetna underpaid $20.

Exhibit C

STATE OF MONTANA

Comparisons of Hospital Statistics
(Based on Quarterly Paid Claims)

	Length of Stay	Covered Charge Per Day	Paid Benefit Per Day	Covered Charge Per Case	Paid Benefit Per Case
Oct. through Dec. 1979					
Active State Employee:	3.82	274.30	252.90	1,046.91	965.24
Blue Cross Plan wide:	4.98	246.17	232.78	1,225.34	1,158.70
Blue Cross National:	6.25	DNA	254.71	DNA	1,591.69
Jan. through March 1980					
Active State Employee:	4.06	296.55	277.37	1,205.47	1,127.48
Blue Cross Plan wide:	5.17	267.08	254.05	1,381.16	1,313.80
Blue Cross National:	6.28	DNA	232.69	DNA	1,461.37
April through June 1980					
Active State Employee:	4.88	258.46	243.50	1,260.16	1,187.20
Blue Cross Plan wide:	5.42	259.82	247.14	1,407.86	1,339.19
Blue Cross National:	6.27	DNA	237.38	DNA	1,488.49
July through Sept. 1980					
Active State Employee:	4.35	292.53	271.89	1,272.89	1,183.06
Blue Cross Plan wide:	5.10	285.74	272.68	1,457.66	1,391.08
Blue Cross National:	DNA	DNA	DNA	DNA	DNA

Exhibit D

Blue Cross
of Montana

P. O. Box 5004
3360 10 Avenue South
Great Falls, Montana 59403
Phone: 761-7310

December 8, 1980

Mr. Ray Wolcott, Jr., Manager
Peat, Marwick, Mitchell & Co.
2000 Commerce Tower
P. O. Box 13127
Kansas City, Missouri 64199

Dear Mr. Wolcott:

The following represents the response by Blue Cross of Montana to the draft report of the audit performed on the State of Montana employee benefit plan.

Page II-2 Claims Verification

The last paragraph of this section leaves the reader with the impression that benefits are paid after coverage has terminated regardless of condition or reason that coverage has terminated. This should be clarified to read "if disability exists at the time coverage is terminated, benefits for the disabling condition may be extended for the period of disability but not to exceed 12 months".

Page II-3 Claims Calculation, Customary Charges

The last paragraph indicates unit values are taken from published values by Workmans Compensation. Unit values are determined by our own survey and only when we have a procedure that was not in the survey do we use the unit values published by the Workmans Compensation Division.

Page II-5 Master Contract Review
Page IV-1 Conclusions
Page IV-2 Recommendations

These comments apply to all three sections referred to above as they relate to the findings on deviations from the master contract for the condition of obesity and the use of LPNs.

We agree with the finding on obesity and agree with the recommendation made. We only wish to emphasize that the benefit has been expanded at the direction of the Montana Insurance Commissioner and is being applied with very strict guidelines.

The finding indicates that the benefit has been expanded to include the services of all Licensed Practical Nurses. In fact, the pencil entry on the master contract applies to one specific case where a registered nurse was not available. It was determined by Blue Cross Plan administration that as an exception to the contract we would provide the benefit on this one case only rather than pay the cost of inpatient care. The decision on this specific case was only made after consultation with the attending physician.

Page IV-1 Conclusions
Page IV-2 Recommendations
Exhibit A Adjudication Errors

These comments are general in nature and apply to all areas where the COB findings are noted.

COB information is requested at the time the subscriber is enrolled. At least annually thereafter, the information we have on file is reverified. This Plan has made the administrative decision to pay claims of less than $500.00 without having current COB information but at the same time as payment is made, we request current information. It is stated in the letter to the subscriber that no further claims will be paid regardless of amount until the request for COB information is returned. If the information is not received in two weeks, a follow-up letter is sent to the subscriber. At the time the information is received and other coverage exists, it is related back to the claim that was paid.

The decision to make payment first, seek the information and then recover any necessary amounts was based on the premise that service to the subscriber in terms of speedy claims process was and is of paramount importance.

It is the position of this Plan that the COB information we receive after the payment is every bit as good as that received before. The cost of doing this can only be related to the Blue Cross of Montana cash flow and has no measurable effect upon the group utilization. The increased subscriber and provider relationships are worth the cost of the cash flow impact.

It should be noted that we anticipate receiving refunds from both providers and subscribers with the use of this procedure.

Further, we would like to thank the auditor for identifying the $8,706.00 claim paid in error. A correction of this item has been made.

General

We would like to thank the auditors for pointing out areas where our operation can be strengthened. We are in agreement with all recommendations made with the exception of changing the dollar amount of the COB procedure. Those recommendations that can be will be implemented immediately and we will work with the State in respect to those which need their involvement.

Yours truly,

Carl J. Tanberg
Vice President, Provider Service
Blue Cross of Montana

CJT:wpd

Exhibit E

Etna
& CASUALTY

P.O. Box 21645
Seattle, Washington 98111

December 9, 1980

Peat, Marwick, Mitchell & Company
2006 Commerce Tower
P.O. Box 13127
Kansas City, Missouri 64199
ATTN: Roy Wolcott, Jr., Manager

RE: STATE OF MONTANA AUDIT

Dear Mr. Wolcott:

Thank you for the opportunity to respond to the results of your recent audit of our processing procedures for the State of Montana. We appreciate your positive comments and constructive criticism. There are several items we would like to clarify.

Eligibility Verification:

Enrollment cards are not sent by the State to Hartford. The State makes up a tape each month that lists all eligible participants and this tape is fed into our computer in Hartford furnishing the Æcclaims system with eligibility.

Customary Charges:

Prevailing fees are gathered from our own claim statistical input. We do not use any information furnished by the Health Association of America. The fee profile is updated every three months by our Home Office but includes six months of data. Charges in excess of 50 percent of the prevailing fee are reviewed by the claims analysis technician. The State contract does not provide any provision that would allow us to solicit more frequent use of preventative procedures or prompt restorations as a cost containment method. This type of cost control is usually handled by a Incentive type dental plan. It is not part of our Cost Control program to interject ourselves between the patient and the dentist as to type of treatment and frequency. We allow benefits for necessary and reasonable treatment to the extent of the policy limitations.

Claim Turnaround Time:

The figures stated in your report do not agree with those given us in your wrap-up. In the wrap-up it was stated the sample used was forty claims with thirty paid in ten days or less. Six had legitimate rationale for the delay in processing and four claims had nothing in file to indicate the reason for delay. Please review your paragraph on turnaround time. Another function the computer serves is to furnish management with a weekly

printout of turnaround time for the total office and each module. The module in which the State's claims are processed had an average turn-around time of 5.6 days for the period of June through November.

Results of Claim Audit:

While a simple average would indicate a $5.00 average overpayment on the 200 files audited, it should be pointed out that twelve errors out of 200 indicates 94 percent of the files were error free. Over half of the total misspent dollars amount was on one claim. All errors shown in exhibit B with the exception of the four identified by PMM & Co. we identified and corrected prior to the audit.

Exhibit B:

We feel the following are questionable chargeable processor errors:

No. 4. We agree that PMM & Co. investigation revealed an overpayment. However, the System would not have edited. The dentist sent in two separate billings each with different dates. Unless the dates were the same on each billing the computer will not edit for possible duplicate charges. The processor would have had no reason to suspect duplicate bill as the dates on the second billing were several months after the original billing.

No. 8. Agree that you identified duplicate charges were paid. This also was a case of the dentist submitting a second billing with different dates of treatment. The dates of treatment were more than a month apart and it is possible to have more than one root canal on a tooth. We feel under the circumstances there is some justification in the manner these two errors occured.

We agree with your statement that the audit results are not indicative of our processing accuracy. We also agree that improvement can be made in the areas stated.

Master Contract:

1. The State furnishes all the eligibility therefore, we do not feel there is a need for this specific information to be on the coverage card. This information is in the Montana Employee Benefit Plan booklet which is available to processors.

2. Specialist examinations are not considered routine in nature as they involve more procedures than an examination by a non-specialist and are considered type B. expense.

3. The coverage card states "the amount shall be equivalant to the same number of amalgam surfaces will be used." It was determined that a crown covers all four surfaces of the tooth.

4. The $5.00 variance is an Administrative liberalization and we do not show it in the Master Contract or the booklet because it is subject to change.

5. Apparantly the contract you had was the original but the renewed date has been amended to August 1.

6. Dentists that make one charge for a combination of services are not generally charging a separate fee for each procedure. Therefore, we benefit up to the prevailing fee of the covered service. We are not benefitting the non-covered items.

Recommendations:

1. A monthly claim detail list is provided the consultant with several items of information on each claim paid during that month including SSA numbers and incurred expense dates. This information is available to the State through the consultant.

2. Processing procedures dictate that all C.O.B. information be completed if it is indicated on the claim form that the dependent is employed.

3. Processors must have the flexibility to override a soft edit if claim indicates the need. If the processor is unsure of the override, the Supervisor is consulted. To have a Supervisor audit each override of a soft edit would have an adverse effect on our T.A.T. If a processor makes incorrect decisions on overrides, then the Supervisor and Auditor/Trainer take corrective measures.

4. This is standard procedure for processors, however you did find one error as the result of failing to follow procedure.

6. Information regarding other plans is obtained when an employee indicates on the claim form that a dependent is employed. However, if the employee certifies that the dependent does not work; we have no means of disputing the certification other than through the employee. We have on hand information about coverages for reference but need to know exact dollar paid to properly coordinate.

We appreciate your comment that Ætna is processing the majority of claims in a timely and accurate manner. This is our objective for each of our Policyholders and comments from the State employees indicated that we have been meeting our objective. If you should need any additional clarification, please don't hesitate to contact us.

Yours truly,

J. Karwoski

J. Karwoski, Assistant Manager
Group Claim Department
Ætna Life Insurance Company

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